16-2325

IN THE

United States Court of Appeals

FOR THE FOURTH CIRCUIT

GREATER BALTIMORE CENTER FOR PREGNANCY CONCERNS, INC.,

Plaintiff-Appellee,

—v.—

MAYOR AND CITY COUNCIL OF BALTIMORE; CATHERINE E. PUGH, in her official capacity as Mayor of Baltimore; LEANA S. WEN, M.D., in her official capacity as Baltimore City Health Commissioner,

Defendants-Appellants,

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
CASE NO. 1:10-cv-00760 MJG
THE HONORABLE MARVIN J. GARBIS

AMICI CURIAE BRIEF OF PUBLIC HEALTH ADVOCATES IN SUPPORT OF APPELLANTS-DEFENDANTS AND IN SUPPORT OF REVERSAL

SIMONA G. STRAUSS
Counsel of Record
P. CASEY MATHEWS
SIMPSON THACHER & BARTLETT LLP
2475 Hanover Street
Palo Alto, California 94304
Telephone: (650) 251-5000
Facsimile: (650) 251-5002

VERONICA R. JORDAN-DAVIS
SIMPSON THACHER & BARTLETT LLP
425 Lexington Avenue
New York, New York 10017
Telephone: (212) 455-2000
Facsimile: (212) 455-2502

Attorneys for Amici Curiae

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

OTHER AUTHORITIES

CONSENT TO FILE AS *AMICI CURIAE*

This brief is filed with the consent of the parties pursuant to Rule 29(a)(2) of the Federal Rules of Appellate Procedure.

INTEREST OF *AMICI CURIAE*[1]

The American Public Health Association, the American Medical Women's Association, Physicians for Reproductive Choice and Health, the Maryland Public Health Association, the Association of Reproductive Health Professionals, the National Health Law Program, the National Physicians Alliance, Joanne Rosen, and Drs. Nadine Peacock and Laurie Schwab Zabin (collectively "*Amici*") respectfully submit this brief *Amici Curiae* in support of Appellants/Defendants.

Amici are public health organizations and individuals, including medical doctors, epidemiologists, public health professionals, and others dedicated to health care, social science research, and health policy. These groups and individuals place a high priority on, and have a great interest in, the advancement of sexual and reproductive health and the protection of a woman's right to personal decision-making regarding her own sexual behavior and reproduction. *Amici*

---

[1] Pursuant to Federal Rule of Appellate Procedure 29(c)(5), counsel for *Amici* represent that no counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than *Amici Curiae* and their counsel made such a monetary contribution.

respectfully submit this brief to share their collective learning about the likely negative impact that an affirmance of the decision below would have on women's immediate and long-term health. *Amici* are as follows:

- The American Public Health Association is an organization whose mission is to champion the health of all people and all communities, strengthen the profession of public health, share the latest research and information, promote best practices, and advocate for public health issues and policies grounded in research.

- The American Medical Women's Association ("AMWA") is an organization of women physicians, medical students and others dedicated to serving as the unique voice for women's health and the advancement of women in medicine. AMWA does this by providing and developing leadership, advocacy, education, expertise, and mentoring. AMWA is an active participant in setting health care policy to promote women's health issues.

- Physicians for Reproductive Health is a doctor-led nonprofit that seeks to assure meaningful access to comprehensive reproductive health services, including contraception and abortion, as part of mainstream medical care. Founded in 1992, the organization currently has over 6,000 members across the country, including over 3,000 physicians who practice in a range of fields: obstetrics and gynecology, pediatrics, family medicine, emergency medicine, cardiology, public health, neurology, radiology, and more. These members, many of whom provide abortion care, include faculty and department heads at academic medical centers and top hospitals.

- The Maryland Public Health Association ("MdPHA") is a nonprofit, statewide organization of public health professionals dedicated to improving the lives of all Marylanders through education efforts and advocacy of public policies consistent with our vision of achieving healthy Marylanders living in health communities. MdPHA is an independently organized and operated state affiliate of the American Public Health Association, a 142-year-old professional organization with more than 50,000 members dedicated to improving population health and reducing the health disparities that plague our state and our nation.

- The Association of Reproductive Health Professionals ("ARHP") brings together health care professionals across disciplines and specialties for evidence-based training and network building. Our members define sexual and reproductive health in broad terms and recognize that the best care is delivered through a team of professionals partnering with an informed patient. ARHP delivers on our educational mission by translating science into practice through producing accredited, peer-reviewed programs. ARHP believes that deceptive or false advertising by Crisis Pregnancy Centers violates basic standards of transparency, and prevents ARHP's key goal of fully informing patients so they can make the best decisions for themselves.

- The National Health Law Program ("NHeLP") is a 50 year-old public interest law firm that works to advance access to quality health care, including the full range of reproductive health care services, and to protect the legal rights of lower-income people and people with disabilities. NHeLP engages in education, policy analysis, administrative advocacy, and litigation at both the state and federal levels.

- The National Physicians Alliance ("NPA") is a non-partisan, non-profit organization that offers a professional home to physicians across medical specialties. NPA creates research and education programs that promote health and foster active engagement of physicians with their communities. The NPA accepts no funding from pharmaceutical or medical device companies.

- Joanne Rosen, J.D., M.A., is Director of the Clinic for Public Health Law and Policy and an Associate Lecturer at the Johns Hopkins Bloomberg School of Public Health. Her teaching and research focus on laws that regulate abortion and reproductive health, laws that regulate sexual intimacy and sexual orientation, and the health disparities associated with these laws. Ms. Rosen has written on the public health harms of crisis pregnancy centers.

- Nadine Peacock, Ph.D., is an Associate Professor, Department of Community Health Sciences and Center for Excellence in Maternal and Child Health at the School of Public Health, University of Illinois at Chicago. Dr. Peacock has a Ph.D. in Biological Anthropology from Harvard University. She serves on a National Science Advisory Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy, and is a former Chair of the Board of Directors of the Guttmacher Institute.

- Laurie Schwab Zabin, Ph.D., is Professor Emeritus at the Department of Population, Family & Reproductive Health at the Johns Hopkins School of Public Health in Baltimore, Maryland. Dr. Zabin obtained her Ph.D. from the Johns Hopkins University School of Hygiene and Public Health. She serves on the Boards of the Guttmacher Institute and was the Founding Director of the Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins School of Public Health. Dr. Zabin has carried out research both in the United States and in the developing world on adolescent sexual attitudes and behaviors, and is included on the Institute for Scientific Information's database of highly cited researchers.

SUMMARY OF ARGUMENT

The court below struck down, as applied to Plaintiff, a Baltimore City Ordinance that required limited-service pregnancy centers, also known as crisis pregnancy centers ("CPCs"), to disclose, through a sign posted on their premises, that they do not provide abortions or comprehensive contraception counseling. If affirmed, that decision would have a markedly negative effect on women's health, delaying women's access to appropriate medical care and medically accurate counseling and thereby increasing the physical and mental health risks arising from a crisis pregnancy.

Requiring CPCs to make the scope of their services clear to the women who come to these centers allows these women to make informed decisions and take steps to improve their health and well-being in a number of fundamental ways. First, immediate disclosure that a CPC does not provide abortion prevents unnecessary delay that women who come to CPCs for the specific purpose of obtaining an abortion would otherwise endure. Minimizing the delay from the time a woman decides to have an abortion until the abortion itself serves at least three important public health goals: (i) it alleviates the increased health risks associated with continued but unwanted pregnancy; (ii) it reduces health risks associated with abortions at later gestations; and (iii) it allows women to receive the medical service they initially sought at the CPC before it is too late to receive it

elsewhere. Second, alerting women that CPCs do not offer comprehensive contraceptive counseling helps minimize the delay in obtaining desired contraceptive counseling, thus preventing unwanted pregnancy and sexually transmitted disease.

As public health advocates, *Amici* are profoundly interested in policies that allow women to obtain desired medical services as quickly and safely as possible. A reversal of the decision below will help advance those policies and thus further women's health.

ARGUMENT

A. Delay In Obtaining An Abortion Poses Health Risks

Women who come to a CPC to obtain an abortion and then discover that the CPC will not provide it (or even refer them to a place that will) are harmed from the delay inherent in this process. That delay can be prolonged—and the risk of harm to these women thereby seriously increased—if the women are not informed as soon as they enter a CPC that they must go elsewhere to obtain the service they came to receive. The harm from the delay comes in two distinct forms: (i) inherent risks of remaining pregnant under certain circumstances, and (ii) increased risks posed by an abortion performed later than necessary. Significantly, these harms are most pronounced for the very population of women who come to CPCs.

1. The Extra Time During Which a Woman Who Wants an Abortion Remains Pregnant Poses Health Risks

For some women, the state of pregnancy itself poses health risks, which can be significant. Thus, a woman who wants to obtain an abortion but remains pregnant because of CPC-induced delay is exposed to preventable health risks associated with her continued pregnancy.

For example, pregnant women may develop deep venous thrombosis (DVTs, or blood clots) because pregnancy results in increased vein pressure. This is a serious condition that can lead to pulmonary embolism or even death. *Deep Vein Thrombosis*, Mayo Clinic, http://www.mayoclinic.org/diseases-conditions/deep-vein-thrombosis/basics/definition/con-20031922 (last visited Jan. 31, 2017). Women with preexisting clotting disorders can manage their pregnancies with the use of blood-thinning medication. *Id.* However, women seeking abortions are far less likely to seek treatment or receive the urgent medical care they require because they are planning to terminate their pregnancies. This is compounded by the fact that many of these women are unaware of the preexisting condition.[2] The

---

[2] Similarly, women with chronic hypertension or preexisting diabetes may experience an exacerbation of their condition at any stage of pregnancy that increases the need for treatment. *See generally* Nat'l Collaborating Ctr. for Women's & Children's Health, *Hypertension in Pregnancy: The Management of Hypertensive Disorders During Pregnancy* 61–75 (2011), https://www.ncbi.nlm.nih.gov/books/NBK62651/; John L. Kitzmiller et al., *Managing Preexisting Diabetes for Pregnancy*, 31 Diabetes Care 1060 (2008);

additional time that these women are *unnecessarily* pregnant is thus time during which they can suffer significant health problems that could have been avoided had they received timely abortion care.

As with abortion-related risks, discussed *infra* in Part A(2), the probability of a pregnancy-related complication that threatens maternal health—and the number of possible complications—increases in later pregnancy. Gestational diabetes, for example, affects approximately 2–10% of pregnant women, but is generally not a concern before 24 weeks of pregnancy. *See Gestational Diabetes*, Cleveland Clinic, http://my.clevelandclinic.org/health/articles/gestational-diabetes (last visited Jan. 31, 2017). Similarly, approximately 5–8% of pregnant women experience preeclampsia (pregnancy-induced hypertension) after 20 weeks, with only rare occurrences of preeclampsia before then. *See About Preeclampsia*, Preeclampsia Foundation, http://www.preeclampsia.org/health-information/about-preeclampsia (last visited Jan. 31, 2017). Thus, abortions before 20 weeks allow some women to avoid medical conditions that they may suffer if they remain pregnant longer than necessary.

Preexisting Diabetes, March of Dimes http://www.marchofdimes.org/complications/preexisting-diabetes.aspx (last visited Jan. 31, 2017).

Finally, some pregnancies develop abnormally and pose serious health risks to women that need to be treated as soon as possible. For example, ectopic pregnancy, in which the pregnancy develops outside the uterus, can result in rupture of the fallopian tubes and life-threatening bleeding if it is allowed to continue. Ectopic pregnancies have a mortality rate of approximately 0.5 deaths per 100,000 live births. Andreea A. Creanga et al., *Trends in Ectopic Pregnancy Mortality in the United States*, 117 Obstetrics & Gynecology 837, 839–40 (2011).[3] Ectopic pregnancy occurs in approximately 2% of all pregnancies, and mortality as a result of ectopic pregnancy is generally due to the failure to seek or receive timely medical attention. *See Ectopic Pregnancy*, Mayo Clinic, http://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/basics/treatment/con-20024262 (last visited Jan. 31, 2017). Separately, molar pregnancies, in which an abnormal pregnancy develops into a tumor, can lead to a potentially deadly cancer if not treated. *See Molar Pregnancy*, March of Dimes, http://www.marchofdimes.org/complications/molar-pregnancy.aspx (last visited Jan. 31, 2017).

[3] The majority of the cited authorities are readily accessible online. However, *Amici* would be pleased to provide any cited papers that the Court wishes to review.

Because women who want abortions generally do not seek or obtain prenatal care or medical services that would diagnose whether their pregnancies were ectopic or molar, delay in abortion—and thus the continued condition of an abnormal and life-threatening pregnancy—poses great harm to these women's health. Additionally, as discussed in section A(3) *infra*, because low-income and minority-race women are more likely to have later term abortions, delay exposes these women, who already suffer from greater morbidity, to still greater mortality and complication risks. Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 Am. J. Pub. Health 1772, 1776 (2013).

2. Health Risks Associated with Abortion Increase as Pregnancy Progresses

Legal abortion is among the safest procedures in medicine, and is significantly safer than childbirth. Sam Rowlands, *Review: Misinformation on Abortion*, 16 Eur. J. Contraception & Reprod. Health Care 233, 234 (2011); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012); Amy G. Bryant et al., *Crisis Pregnancy Center Websites: Information, Misinformation and Disinformation*, 90 Contraception 601 (2014). Indeed, abortions performed at all gestations and by all methods are thirty

times less likely to cause death than childbirth, Rowlands, *supra*, at 234, and surgical abortion in the United States is seventy times less likely to cause death than childbirth. *Id.* at 235.

Medical abortion (*i.e.* abortion performed using medication only, without the need for any surgery) is a common method of abortion early in pregnancy, approved by the FDA for use through ten weeks gestation.[4] *Mifeprex (Mifepristone) Information*, U.S. Food & Drug Admin., http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111323.htm (last visited Jan. 31, 2017). Some women choose medication abortion to avoid a surgical procedure, and an increasing percentage of women have chosen medical abortion in recent years. Tara C. Jatlaoui et al., *Abortion Surveillance – United States, 2013*, Morbidity & Mortality Wkly. Rep.: Surveillance Summaries, Nov. 25, 2016, at 1, 1 ("[F]rom 2004 to 2013, use of early medical abortion increased 110% (from 10.6% of abortions to 22.3%)."). Medical abortions become less effective later in pregnancy, however, and thus are generally not performed in America after ten weeks of gestation. *See* M. Lokeland

---

[4] While rare, complications from medical abortion include hemorrhage, incomplete abortion, and infection. Elizabeth G. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 26, 29, 31 (2013); Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) [hereinafter Upadhyay et al., *Incidence*].

et al., *Medical Abortion at 63 to 90 Days of Gestation*, 115 Obstetrics & Gynecology 962, 964 (2010) (finding that up to 8.7% of medical abortions performed between 63 and 90 days of gestation resulted in incomplete abortion and other complications); David A. Grimes, *The Choice of Second Trimester Abortion Method: Evolution, Evidence and Ethics*, 16 Reprod. Health Matters 183, 184–85 (2008). At this point, some women who would have preferred an abortion without surgery (*i.e.*, a medical abortion) will no longer have that option and instead will need to undergo a *surgical* abortion.[5] Justin Diedrich & Jody Steinauer, *Complications of Surgical Abortion*, 52 Clinical Obstetrics & Gynecology 205, 205 (2009). This loss of choice is particularly unfortunate for certain women because medical abortion may be the only or the preferred option in certain situations, such as when obesity limits visualization of the cervix, Helena von Hertzen & David Baird, *Frequently Asked Questions About Medical Abortion*, 74 Contraception 3, 4 (2006), or when uterine fibroids make access to the pregnancy more difficult or infeasible. *See, e.g.*, Mitchell D. Creinin, *Medically Induced Abortion in a Woman with a Large Myomatous Uterus*, 175 Am. J. Obstetrics & Gynecology 1379, 1379 (1996).

---

[5] Although complications from surgical abortion are also rare, risks include uterine perforation and cervical laceration, as well as anesthesia-related problems. Diedrich & Steinauer, *supra*, at 206.

Significantly, however, the complication rate of abortion increases as gestational age increases. Diedrich & Steinauer, *supra* at 205, 206. Moreover, the complication rate is increased for both medical and surgical abortions. Dehlendorf et al., *supra*, at 1776; Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Pub. Health 1687, 1687 (2014) [hereinafter Upadhyay et al., *Denial*]. Further, the risks, however small, increase exponentially over the course of pregnancy, meaning that any additional delay causes a disproportionately increased risk of complications. Diedrich & Steinauer, *supra*, at 205; Mary Gatter et al., *Efficacy and Safety of Medical Abortion Using Mifepristone and Buccal Misoprostol Through 63 Days*, 91 Contraception 269, 271–72 (2015).[6] For example, the risk of major complications for surgical abortions in the first trimester is only 0.16%. Upadhyay et al., *Incidence*, *supra*, at 178. That risk, while still very low at 0.41%, is more than doubled for abortions performed in the second trimester or later. *Id.*

The risk of death from abortion, while still extremely low and lower than from childbirth, also increases as gestational age increases. Women whose abortions are performed in the second trimester (at or after 13 weeks of gestation)

---

[6] The risks of incomplete abortion, uterine hemorrhage, placenta accreta, disseminated intravascular coagulophathy (DIC), perforation, and amniotic fluid embolism all increase with gestational age. Upadhyay et al., *Incidence*, *supra*, at 179–80, 182.

have higher abortion-related mortality rates than women whose abortions are performed during the first 8 weeks of pregnancy. Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 Obstetrics & Gynecology 258, 263 (2015). Indeed, "[g]estational age at the time of the abortion remains the strongest risk factor for abortion-related mortality." *Id.* Significantly, the risk of mortality—as with complications—increases disproportionately with time when women are forced to undergo unnecessary delay in receiving an abortion. The mortality rate for abortions (*i.e.*, the number of abortion-related deaths per every 100,000 legal induced abortions) is 0.3 before 8 weeks, 0.5 at 9–13 weeks, 2.5 at 14–17 weeks, and 6.7 at or after 18 weeks. *Id.* at 262.

In sum, legal abortion overall remains a very safe procedure, but risks increase when a woman's access is delayed. From a public health standpoint, any risks that can be avoided should be avoided. *See, e.g.*, Am. Coll. of Obstetrics & Gynecology, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481 (2007) ("Nonmaleficence is the obligation not to harm or cause injury . . . ."). Those readily avoidable risks include increased risk stemming from delay to access to abortion. It is essential to view the increasing risks of abortion that accompany advancing gestational age in comparison with the significantly greater risks of continuing a pregnancy, as noted above.

3. These Delays Have a Greater Impact on the Very Population of Women Who Seek Abortions at CPCs

As a group, the women who seek services at CPCs are young, minority-race women who have limited economic means and low educational attainment. They also are the very women most likely to be negatively impacted by delay in obtaining abortion. *See* Melissa Kleder & S. Malia Richmond-Crum, *The Truth Revealed: Maryland Crisis Pregnancy Center Investigations* 2 (2008).

The reasons this population of women are most likely to go to CPCs are many: (i) unintended pregnancies are more common in young minority women with limited means and low education, Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 New Eng. J. Med. 843, 849 (2016); (ii) these women are less likely to know about options other than CPCs; (iii) younger and less affluent women are more likely to be enticed by the free services, such as free pregnancy tests, offered by CPCs; and (iv) CPCs specifically target women in these demographics with their advertising campaigns. J.A. at 419 (describing how CPCs use abstinence education funding as a way to get into public schools to reach populations of young women); Katelyn Bryant-Comstock et al., *Information About Sexual Health on Crisis Pregnancy Center Web Sites: Accurate for Adolescents?*, 29 J. Pediatric & Adolescent Gynecology 22, 24 (2016) ("Of the [CPC] Web sites that had information about condoms or STIs, 91.8% (78/85) had pictures or videos of youth on their home

page—clearly targeting a younger population."). Consistent with the statistics, the record below reflects that Plaintiff deliberately targeted young, minority women with its advertising. J.A. at 793 (noting that bus ads would run near Coppin State University, Baltimore City Community College, and a local mall and so would be "a good test of our effectiveness in reaching students")); *id.* at 798 (asking if bus ads should feature "an African-American woman, a Hispanic woman, or both?").

Compounding the problem, younger, poorly educated women with limited means also tend to seek services later in their pregnancies. Dehlendorf et al., *supra*, at 1776; Maureen Paul et al., *Management of Unintended and Abnormal Pregnancies* 319 (2009) ("Low-income and disadvantaged women have more trouble accessing abortion services and tend to present for care at later gestational ages."), *citing* Stanley K. Henshaw & Lawrence B. Finer, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 Persp. on Sexual & Reprod. Health 90, 93 (2006). Again, the reasons for this are manifold. For example, minors are more likely to have irregular menstrual cycles and thus may not even realize that they are pregnant until the second trimester.[7] Minors

---

[7] Exacerbating this is the fact that many women, regardless of age, are further in their pregnancies than they even realize by the time they seek care. *See* K Blanchard et al., *A Comparison of Women's, Providers' and Ultrasound Assessments of Pregnancy Duration Among Termination of Pregnancy Clients in South Africa*, 114 Brit. J. Obstetrics & Gynecology 569, 571 (2007) (reporting that

generally also are less willing, from a psychological standpoint, to accept that they are pregnant and to take action to deal with the situation. They thus typically require more time, even after they realize that they are pregnant, to seek and obtain medical attention. Minors also fear (and thus delay) telling their parents about their pregnancies, Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335, 343 (2006), which results in even greater delays in states requiring parental notification or consent for abortions, including Maryland. *See* Md. Code Ann., Health-General § 20-103 (2015). In addition, minors generally take somewhat longer to make decisions about how to address medical issues, including abortion. *See* Finer et al., *supra*, at 338–40. Finally, even after they decide to obtain an abortion, given their relative lack of independence and resourcefulness, and their need for heightened confidentiality, minors have a more difficult time navigating the health care system. *Id.* This difficulty is exacerbated by funding concerns, which almost all minors experience.

Indeed, limited financial resources—*regardless of age*—is correlated with the postponement of medical services, including abortion. Marshall H. Medoff, *Race, Restrictive State Abortion Laws and Abortion Demand*, 41 Rev. Black Pol.

---

women's estimates of gestational age were an average of 19 days shorter than estimates based on ultrasound).

Econ. 225, 238 (2014) ("A [state] Medicaid funding restriction reduces the abortion rate of white women by 2.0%, black women by 4.1% and Hispanic women by 10.6%."); Upadhyay et al., *Denial*, *supra*, at 1688. Moreover, low-income women may find prohibitive not only the cost of the abortion itself, but also any requirements for childcare during clinic visits and recuperation, transportation and hotel expenses, and having to take time off from work. These additional factors add to the financial burden of the procedure and cause further delays. Ushma D. Upadhyay et al., *Denial*, *supra*, at 1687. According to one recent study, 36.5% of women in their first trimester of pregnancy cited the cost of an abortion and travel to and from the provider as a reason for their delay in getting an abortion. Among women who were *turned away* from providers due to gestational age of pregnancy, 58.3% cited these costs as a cause of delay. *Id.*, at 1688. Moreover, the later the gestation, the greater the abortion cost, exacerbating the delays due to financial circumstances. *Id.* ("Because later abortions are more complex procedures, often occurring over 2 or more days, they are also more costly; the average charge for an abortion at 10 weeks is $543 compared with $1562 for an abortion at 20 weeks.").[8]

---

[8] For example, difficulty in getting Medicaid programs to pay for an abortion is "significantly associated with delay" for women on Medicaid who seek to terminate their pregnancy. Diana G. Foster et al., *Predictors of Delay in Each Step Leading to an Abortion*, 77 Contraception 289, 292 (2008); Stanley K. Henshaw et

Thus, the women who come to CPCs for abortions on average tend to be more susceptible to delay and will be more advanced in their pregnancies than those who go to private physicians' offices and abortion providers when they first learn they are pregnant but want an abortion. *See* Finer et al., at 339 (reflecting a longer passage of time from last menstrual period to abortion for young women, non-white women, and poor women). The result is that additional delay at the CPCs results in an even greater risk to these women's health.

B. Delay Makes It More Likely That Certain Women Will Never Be Able To Receive The Medical Treatment They Sought At The CPC

As a matter of public health policy and legal policy, women should have access to available medical services without unnecessary obstacles. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992) (indicating that legislation cannot unduly burden a woman's access to abortion services); *Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention*, Am. Pub. Health Ass'n, http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights (last visited Jan. 31, 2017). Although the majority of abortions in the United States take place during the first trimester of a woman's

---

al., *Restrictions on Medicaid Funding for Abortions: A Literature Review* 1 (2009), http://www.guttmacher.org/pubs/MedicaidLitReview.pdf.

pregnancy, approximately 8.4% of abortions occur after 13 weeks of gestation. Jatlaoui et al., *supra*, at 1. Most women who had second trimester abortions, however, would have preferred to have had the procedure earlier. Karen Pazol et al., *Abortion Surveillance — United States, 2012*, Morbidity & Mortality Wkly. Rep.: Surveillance Summaries, Nov. 27, 2015, at 1, 8; Upadhyay et al., *Denial*, at 1687. Significantly, delay in obtaining a desired abortion not only increases the woman's health risks but also makes the service sought either harder to obtain or, at some point, impossible to obtain.

First, abortions become more expensive as pregnancy continues, potentially limiting a woman's ability to obtain an abortion, particularly for the very women who typically come to CPCs for abortion services. Upadhyay et al., *Denial*, at 1687 (showing that the cost for abortion at 20 weeks is roughly triple the cost of abortion at 10 weeks); *see also* Medoff, *supra*, at 238.

Second, the number of abortion providers willing to perform abortions is reduced as pregnancy continues, with very few providers available after the second trimester. "According to a national survey of abortion providers, 23% offer abortions after 20 weeks' gestation, and 11% do so at 24 weeks." Upadhyay et al., *Denial*, at 1687. Thus, additional delay may require some women to travel farther to obtain an abortion, if they can even find an abortion provider at that point in their pregnancies. And, consistent with the population that tends to go to CPCs,

the women who are denied abortions based on the gestational period of their pregnancy are "younger and less-likely to be employed," further restricting low-income and younger women from obtaining an abortion. *Id.* at 1688.

Finally, abortion does not remain an option for women for the entire duration of pregnancy. *State Policies on Later Abortions*, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions (last visited Jan. 31, 2017) (noting legal restrictions on abortion based on gestational age). Thus, delay in obtaining abortion for some women will result in the loss of that option altogether even though it is the option they want and have chosen based on their circumstances.

Women should be able to obtain the legal medical services they elect, as appropriate for their circumstances. Women are harmed when medical options that were once available to them are no longer available as a result of avoidable delay.

C. Delay In Obtaining Desired and Comprehensive Contraceptive Counseling Can Cause Substantial Harm To Women

Women's overall health and well-being are vastly improved when they (i) have control over the timing of their pregnancies (or whether to become pregnant at all) and (ii) are able to prevent disease.

Unless they take precautions, sexually active women are at risk of becoming pregnant[9] or contracting a sexually transmitted infection ("STI"). Thus, women seeking information about contraception should be provided that information in a timely manner in order to prevent unintended pregnancy or disease. If that information will not be provided, or if that information will not be provided in a comprehensive manner, women should be informed of that fact as soon as possible so that they may obtain it elsewhere.

Some women come to CPCs specifically to receive information about contraception. Other women come to CPCs with the belief they are pregnant, but then learn that they are not. When these women learn that they are not pregnant, many of them will seek or receive advice about how to avoid unwanted pregnancy in the future. Because a woman who believes she is pregnant clearly has engaged in sexual activity, and often unprotected sexual activity, a negative pregnancy test presents "a 'teachable moment' and a valuable opportunity to engage [the woman] in responsible and comprehensive reproductive health care." Alison Moriarty Daley et al., *Negative Pregnancy Tests in Urban Adolescents: An Important and Often Missed Opportunity for Clinicians*, 31 Pediatric Nursing 87, 87–89 (2005)

---

[9] The rate of unintended pregnancy is greater for poor women, uneducated women and minority-race women, the very women most likely to go to CPCs. Finer & Zolna, *supra* at 845 (describing 2011 figures).

(discussing the importance of targeting teenagers with negative pregnancy tests for appropriate reproductive counseling); Laurie Schwab Zabin et al., *Adolescents with Negative Pregnancy Tests: An Accessible At-Risk Group*, 275 J. Am. Med. Ass'n 113, 113–17 (1996) (concluding that adolescent girls with negative pregnancy test results may be identified by the health care system at the time of negative test in time to prevent early childbearing); Laurie Schwab Zabin et al., *Subsequent Risk of Childbearing Among Adolescents with a Negative Pregnancy Test*, 26 Fam. Plan. Persp. 212, 212–17 (1994) (concluding that among adolescents aged 17 and younger, there is considerable potential for preventative counseling at the time of a negative pregnancy test).

Although CPCs hold themselves out as comprehensive medical providers, women who go to CPCs for contraceptive counseling cannot obtain the services they seek on the premises.[10] If women seeking information about contraception at CPCs or women with negative pregnancy tests at CPCs are not informed that the only two options presented by CPCs (abstinence and rhythm method) are not

---

[10] The focus of the Public Health Advocates in this *amicus* brief is to explain the public health consequences resulting from the provision of false or misleading information about the true nature of CPC services. *Amici* defer to the parties and other *amici* to provide the Court with the particulars as to the false information disseminated by CPCs with respect to services they provide.

comprehensive, they may not realize that other options are available.[11] In addition, any misinformation they are given with respect to the efficacy rates of condoms or other contraception could result in their later failure to use contraception that otherwise would have been beneficial in preventing unwanted pregnancy and/or STIs. In both situations, the opportunity for a health-critical "teachable moment" and the provision of accurate information important to women's long-term health will be missed. As a result, the very risks that these women may wish to avoid—disease and pregnancy—are more likely to be realized. Significantly, those risks are largely avoidable when women are informed that they must seek appropriate information and services elsewhere.

[11] This is particularly true of young and poorly educated women, who are at a pronounced informational and power disadvantage relative to CPC workers. Indeed, minors generally have less information and are thus even more reliant on seemingly professional advice.

CONCLUSION

Amici respectfully request that the Court reverse the decision below.

Dated: February 3, 2017

Respectfully submitted,

/s/ Simona G. Strauss
Simona G. Strauss
P. Casey Mathews
SIMPSON THACHER & BARTLETT LLP
2475 Hanover Street
Palo Alto, California 94304
(650) 251-5000
(650) 251-5002 (fax)

Veronica R. Jordan-Davis
SIMPSON THACHER & BARTLETT LLP
425 Lexington Avenue
New York, New York 10017
(212) 455-2000
(212) 455-2502 (fax)

Attorneys for Amici Curiae

CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), I hereby certify that this brief contains [5,427 words], excluding the portions of the brief exempted by Federal Rule Appellate Procedure 32(a)(7)(B)(iii). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in Times New Roman, 14 point font.

/s/ Simona G. Strauss
Simona G. Strauss
Attorney for *Amici Curiae*

CERTIFICATE OF SERVICE

I hereby certify that on February 3, 2017, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the appellate CM/EMF system.

I hereby certify that on February 3, 2017, the foregoing document was served on all parties or their counsel of record through the CM/EMF system.

/s/ Simona G. Strauss
Simona G. Strauss
Attorney for *Amici Curiae*

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

APPEARANCE OF COUNSEL FORM

BAR ADMISSION & ECF REGISTRATION: If you have not been admitted to practice before the Fourth Circuit, you must complete and return an Application for Admission before filing this form. If you were admitted to practice under a different name than you are now using, you must include your former name when completing this form so that we can locate you on the attorney roll. Electronic filing by counsel is required in all Fourth Circuit cases. If you have not registered as a Fourth Circuit ECF Filer, please complete the required steps at Register for eFiling.

THE CLERK WILL ENTER MY APPEARANCE IN APPEAL NO. 162325 as

☐ Retained ☐ Court-appointed(CJA) ☐ Court-assigned(non-CJA) ☐ Federal Defender ☑ Pro Bono ☐ Government

COUNSEL FOR: Public Health Advocates

_____ as the
(party name)

☐ appellant(s) ☐ appellee(s) ☐ petitioner(s) ☐ respondent(s) ☑ amicus curiae ☐ intervenor(s) ☐ movant(s)

Simona Strauss
(signature)

Simona G. Strauss
Name (printed or typed)

650-251-5203
Voice Phone

Simpson Thacher & Bartlett LLP
Firm Name (if applicable)

650-251-5002
Fax Number

2475 Hanover Street

Palo Alto, CA 94304
Address

sstrauss@stblaw.com
E-mail address (print or type)

CERTIFICATE OF SERVICE

I certify that on Feb. 3, 2017 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

Simona Strauss
Signature

2/3/2017
Date

01/19/2016 SCC